2022/2023 INFLUENZA VACCINE CONSENT FORM

1. PATIENT INFORMATION

Patient Full Name

Address

Phone Number

Health Card Number

Gender

Birth Date

Emergency Contact

Emergency Contact Phone Number

Physician/ Nurse Practitioner

Physician/NP Phone Number

2. COVID SCREENING AND HEALTH INFORMATION

As of today:	Yes	No
Do you have a fever, infection, shortness of breath, chest pain or feel unwell		
Are you experiencing cold, flu or COVID-19-like symptoms, **even mild ones**? Symptoms include: fever, chills, cough, shortness of breath, sore throat and painful swallowing, stuffy or runny nose, loss of sense of smell, headache, muscle aches, fatigue or loss of appetite, conjunctivitis, dizziness, confusion, nausea, vomiting, abdominal pain, skin rashes, discolouration of fingers or toes - or **any other suspected COVID-19 symptom**?		
Have you had a COVID-19 test in the past 14 days? If yes, please enter date and result.		
Within the last 14 days, did you **provide care** or have **close contact** with a person with confirmed COVID-19 or someone who is under investigation for COVID-19?		
Have you ever had a flu shot before?		
Have you received any vaccinations in the last 6 weeks?		
Have you ever fainted or had a serious reaction to any previous injection or vaccine(s) including Guillain-Barre Syndrome?		
Do you have any allergies? Please list: (foods, medications, latex, vaccine components)		
Do you have any chronic health conditions or immunodeficiencies? Please list:		
Are you currently on any medications or immunosuppressants? Please list:		
Do you have an active neurological condition?		
Are you pregnant or breastfeeding?		
Have you received blood products (containing immunoglobulin) in the last 3 months?		

3. PATIENT CONSENT

- I have read or had explained to me and understand the benefits, side effects and risks of receiving and risks of not receiving the influenza vaccine.
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to stay in the pharmacy for at least 15 minutes after receiving the influenza vaccine or as directed by the pharmacist/nurse.
- I authorize my pharmacist/nurse to notify my physician/nurse practitioner and/or public health of the vaccine received, any adverse events experienced and/or to contact me with any follow-up if needed.

AND: ☐ I consent to receive the influenza vaccine today **OR** ☐ I consent on behalf of the patient to receive the influenza vaccine today

Print Name_____ Relationship (if applicable) _____

Date_____ Phone Number _____

Signature _____

OR: ☐ Verbal consent provided by patient/agent (circle one) Consent given to _____

4. VACCINE INFORMATION

PHARMACY USE ONLY:

Pharmacy Name_____ Pharmacy Phone Number _____

Influenza Vaccine Dosage ☐ 0.5mL Other	**Administration Site**	Deltoid: ☐ R ☐ L Other	**Notes/Observations (15-30 min wait)**
☐ Afluria Tetra ☐ Fluad ☐ Flulaval Tetra ☐ FluMist Quadrivalent ☐ Fluzone HD Quadrivalent ☐ Fluzone Quadrivalent ☐ Other	**Administration Route**	☐ IM ☐ Intranasal	
	Immunization Date		
	Immunization Time	☐ AM ☐ PM	
	Pharmacist/Nurse Name		
Lot No.	**License No.**		
Expiry Date	**Signature**		

Communication to other Health Care Providers (physician, nurse practitioner, public health) via:

☐ Fax

☐ Electronic Provincial Registry